ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Sept. 20, 2018 Case Number: 19-29

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Dr. Julie Yeager

Premise Name: Sonoran Animal Hospital

Premise Address: 7637 E Speedway Blvd

City: Tucson State: AZ Zip Code: 85710

Telephone: (520)886-8888

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Tsai, Margaryta

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: n/a Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME, PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

RECEIVED
SEP 20 2018
BY:

C. **PATIENT INFORMATION (1):**

Name: ARCHI

Breed/Species: African Gray parrot

Age: 4 years Sex: Male Color: Grey

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

Dr. Julie Yeager
7637 E Speedway Blvd.
Tucson, AZ 85710
(520) 886 - 8888

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

n/a

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: 09/16/18

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

To Whom It May Concern:

I am writing this letter to file a complaint against Dr. Julie Yeager, DVM, AZ 4928. Dr.Yeager killed my African Gray Parrot, Archi, while Archi was undergoing an elective procedure to remove a metal band around Archi's leg. My complaint does not criticize Dr. Yeager's veterinary skill or the resulting pathology report (see enclosed reports), which indicated that an infection 4 hours to 1 day old may have caused the heart attack that killed Archi, but rather that Dr. Yeager did not provide me with enough information about the risks associated with general anesthesia and, thus, I was not given informed consent regarding an elective procedure. I would never have subjected Archi to a procedure that carried the risk of death over a metal band that Archi chewed at but was not causing him any harm. Dr. Yeager should have informed me of the risk, done appropriate bloodwork to determine if he did have an infection that would have put him at greater risk of death, and then scheduled another time for the procedure to be done, if I felt it was still necessary. Her lack of respect for the danger of anesthesia, the possible effects on Archi, and for not disclosing all the facts are what led to Archi's death. She, as a licensed professional, should be reprimanded in some way for this dangerous omission. The facts of the case are clearly summarized in her notes (see enclosed notes) where there is no mentioned of informed consent. There is, however, mention of the estimate for the anesthesia and band removal. This has to beg the question of what was more important...to talk about the possibility of death during the procedure or making sure that I understand how much it will cost?

I am asking the Veterinary Board to begin an investigation so as to ascertain why Dr. Julie Yeager did not provide me with informed consent. This lack of informed consent led to the death of my companion after only 4 years of life. I realize that nothing will bring Archi back, but I want Dr. Julie Yeager to understand the responsibility that she wields as a licensed professional. She is not just some one pretending to know veterinary medicine but has been condoned and sanctioned by the Veterinary Board to practice her craft. As such an individual, the public has the right to expect that certain skills and knowledge are possessed by her. One such knowledge should be the risk associated with anesthesia. When I asked her why she did not inform me of risks asociated with the procedure, her answer was "I'm sorry. I didn't know." Another expectation of a licensed professional is that the professional will pass such knowledge onto the client so that the client can make an informed decision.This last thing was not done and thus brings into question Dr. Julie Yeager's ability as a licensed individual.

I come from a family of medical doctors. If anyone of them had done a procedure without informed consent, not only would they have suffered a lawsuit and lost, but there would have been a strong possibility of losing their license, whether temporarily or permanently. Not giving informed consent is very serious in human medicine. It should be the same with veterinary medicine. Our pets are our family. They are not just animals to us. They can't just be replaced. They are our confidants, our source of joy, and, unfortunately, our source of greatest sorrow. Please, see that Dr. Julie Yeager remembers that next time she treats another person's pet (family member).

Thank you for your time and consideration.

Sincerely,

Margaryta Tsai

Julie Yeager, DVM
7637 E. Speedway Blvd
Tucson, AZ 85710

October 8, 2018

Arizona State Veterinary Medical Examining Board
1740 W. Adams St., Suite 4600
Phoenix, AZ 85007

19-29 In-Re: Julie Yeager, DVM

Dear Members of the Board,

I have received your September 24, 2018 correspondence regarding the complaint made against me by Margaryta Tsai concerning my treatment of "Archi." Enclosed, please find a copy of the entire medical record for Archi. In addition, I am providing the following statement regarding my treatment of Archi.

Ms. Tsai presented Archi, a 4 year old male Congo African Grey on 7/26/2018 for yearly exam and evaluation of a new behavior, chewing on the ID band located on the right distal leg. During physical exam Ms. Tsai indicated that he had begun chewing on his band over the last several weeks and paying a significant amount of attention to it. On exam there were no apparent lesions to the limb, however some feather destruction was present. I discussed with Ms. Tsai that while the leg appeared normal, it is possible that the patient could have underlying pain or irritation or that the chewing could be a behavioral problem. A complete examination was performed, which was normal with the exception of the above-mentioned complaints and mild overweight body condition.

I explained to Ms. Tsai that because of the history of feather destructive behavior and the significant amount of attention that the patient was paying to the band, I was concerned that the band chewing could progress to chewing of or damage to the foot and leg, or that the band could become caught in toys, cage furniture, or other objects resulting in significant injury. I advised her that the band could be removed, however, it would require anesthesia because if the leg moves at all during removal, it could result in injury to the leg. She asked if there was any risk of leaving the band on and I advised that there was risk of injury to the leg if left in place. Ms. Tsai indicated that she understood and would like to have the band removed. Because the client was already familiar with anesthesia as the patient had previously undergone two anesthetic procedures, it was my belief that Ms. Tsai understood the risks and benefits of performing the procedure.

Brief anesthesia is often indicated in avian medicine to obtain samples and perform procedures that in other species may be performed without anesthesia. Because anesthesia would be very short, physical exam did not reveal significant abnormalities, and there was a risk of significant injury to the leg if the band was not removed, I recommended removal of the band at this time. Ms. Tsai elected to proceed with band removal.

After the estimate was discussed and Ms. Tsai gave consent, Archi was brought to the back and mask induced and maintained with isoflurane at 1-2%. His heart rate and respiratory rate were continuously monitored with normal respiratory rate around 30 with deep, normal chest movement and heart rate maintaining between 200-230 beats per minute. A blood sample was collected for yearly screening

bloodwork and the patient was then positioned for band removal at which time (approx. 3min after induction) he acutely stopped breathing and his heartbeat was lost on auscultation. Isoflurane was discontinued and oxygen was administered. He was then intubated and CPR was initiated.

I then updated Ms. Tsai about what had transpired. I discussed that we had started CPR, however there was not yet a return of heartbeat or spontaneous respiration. Ms. Tsai was very upset and asked why we didn't know this would happen and referenced Archi's previous anesthesias, reiterating that he had two previous surgeries and didn't have any problems with anesthesia. I expressed my deepest sympathy and advised her that we had no indication on physical exam or reason to believe that he would have an increased anesthetic risk. I again expressed my deepest sympathy and advised that we would continue with CPR and update her shortly.

I returned to the patient where no heartbeat or spontaneous respirations had yet returned with continued CPR efforts. CPR was continued, however after approximately 10 minutes no heartbeat or spontaneous respirations returned.

I returned to inform Ms. Tsai that our CPR had been unsuccessful to this point. I expressed my sympathy and advised her that at this point it was very unlikely that he would respond to CPR. Ms. Tsai elected to discontinue CPR. I informed Ms. Tsai that I suspected an undetectable medical problem was present. Ms. Tsai was very upset and again asked why we didn't know this would happen. I again indicated to her that Archi's physical exam did not reveal any issues that would indicate he had increased anesthetic risk and if we had known I would never have presented this option. I told her how very sorry I was for her loss.

I recommended that a necropsy and histopathology be performed to look for an explanation. Ms. Tsai indicated that she would like a necropsy and histopathology to be performed. I again expressed my deepest sympathy for her loss. I offered to bring Archi to her so that she could say goodbye. She declined, but the man who came to the appointment with her elected to see Archi and say goodbye. I brought him to see Archi, and when he was done escorted him back to Ms. Tsai and they left the exam room. Approximately 20min later Ms. Tsai returned and relayed that she did not want the necropsy performed. We advised that this can be performed by a third party/pathologist and she elected to proceed.

It is extremely unfortunate that Archi passed away during the procedure, however performing the procedure at this time was necessary for Archi's health. He had already begun to show self-mutilating behavior, and there was significant risk to leaving the band on. Furthermore, aside from changes in behavior related to the metal band, there were no abnormalities in Archi's history or on physical examination to indicate more than minimal anesthetic risk for this procedure which was to last approximately 5 minutes. Archi had also been through several anesthetic procedures without complication. If you need any additional information, please contact me.

Sincerely,

Julie Yeager, DVM

Julie Yeager, DVM

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Donald Noah, D.V.M. - Chair
Amrit Rai, D.V.M.
Adam Almaraz
Christine Butkiewicz, D.V.M.
William Hamilton

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Michael Raine – Assistant Attorney General

RE: Case: 19-29
Complainant(s): Margarita Tsai
Respondent(s): Julie Yeager, DVM (License: 4928)

SUMMARY:
Complaint Received at Board Office: 9/20/18
Committee Discussion: 12/4/18
Board IIR: 1/16/19

APPLICABLE STATUTES AND RULES:
Laws as Amended July 2014 (Salmon); Rules as Revised September 2013 (Yellow)

On July 26, 2018, "Archi," a 4-year-old male African Gray parrot was presented to Respondent for exam and possible leg band removal. After discussion, Complainant agreed to have the metal band on the bird's right leg removed.

Shortly after the bird was anesthetized, he arrested. CPR was initiated but was unsuccessful.

Complainant stated that she was unaware that a risk of anesthesia could be death.

Complainant was noticed and appeared telephonically.
Respondent was noticed and appeared telephonically; Attorney, David Stoll appeared.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Margarita Tsai*
- Respondent(s) narrative/medical record: *Julie Yeager, DVM*
- Witness(es) narrative: *Sonoran Animal Hospital staff – Stacy Calen*

PROPOSED 'FINDINGS of FACT':

1. On July 26, 2018, the bird was presented to Respondent for an exam. Complainant reported that the bird had recently been chewing on his leg band; Respondent felt the chewing could be behavioral vs discomfort or pain. Upon exam, the bird had a weight = 502 gms, a heart rate = 220bpm and a respiration rate 30rpm; BCS = heavy. The bird had some mild feather destruction of coverts over most of chest, abdomen, and ventral wings. There was no increase in respiratory rate or effort at this visit with restraint as in prior visit. The bird also had mild pododermatitis of the left plantar foot – suspected due to heavy body condition and abnormal weight bearing associated with missing toes.

2. Respondent discussed the leg band with Complainant – there was no obvious physical abnormality or apparent source of pain; band could be removed. Band removal would require anesthesia as any movement while the band was being removed could cause harm. Complainant asked about the risks of leaving the band on and Respondent explained that it was possible for the band to get hung up on toys, cages, etc and result in injury. Technical staff member, Ms. Calen, went over the estimate for anesthesia and band removal – Complainant elected to proceed. Respondent also recommended complete avian profile; Complainant approved.

3. The bird was masked down with isoflurane and was maintained on the lowest effective isoflurane level 1 – 2%, heart rate = 200 – 230bpm and a respiration rate = 30rpm, with deep chest movements. Blood was collected for testing.

4. After approximately 3 minutes, the bird abruptly stopped breathing; anesthesia was turned off, oxygen continued, and there was no heart beat on auscultation. Respondent intubated the bird and began positive pressure ventilation and chest compressions – atropine and epinephrine was administered via entrotracheal tube. No response. Respondent started IV fluids – warmed and slow.

5. Respondent spoke Complainant to relay what had transpired and they were continuing CPR.

6. Replaced the endotracheal tube due to blockage, continued chest compressions and PPV, administered additional epinephrine and atropine IC, and a second bolus of fluids. Still no response. Respondent discussed the bird's condition with Complainant and recommended discontinuing CPR – Complainant agreed and the bird passed away. A necropsy was recommended and approved.

7. Necropsy was performed and revealed:
   1. *Myocarditis, heterophilic, multifocal, mild, heart; and*
   2. *Atherosclerosis, multifocal, mild to moderate, aorta and brachycephalic trunk.*

8. Histopathology second opinion revealed:
   1. *Multiple organs: Variable congestion;*
   2. *Heart: Mild to moderate atherosclerosis;*
   3. *Adrenal gland: Mild vacuolar degeneration, interrenal cells; and*

4. *Heart: Mild multifocal heterophilic myocarditis.*

9. Complainant stated in her complaint that Respondent did not provide her with enough information about the risks associated with general anesthesia,

10. According to Respondent since Complainant was already familiar with anesthesia as the bird had previously undergone two anesthetic procedures, it was her belief that Complainant understood the risks and benefits of performing the procedure.

COMMITTEE DISCUSSION:

The Committee discussed that this case was an unfortunate anesthetic death that was likely due to an underlying issue. Although this is a rare event, it can occur at any age regardless of underlying pathology in birds. Some blood tests can reduce the occurrence, it is not a guarantee.

In this case, the Respondent assumed that since the bird had undergone general anesthesia in the past, the Complainant would remain aware of the risks. However, risks change over time as the pet ages and potentially become infected with chronic or infectious type diseases.

The statutes allow for a signed written anesthesia release or a verbal when witnessed by one other person. In this case, there was a technical staff member that witnessed Complainant authorizing the anesthesia. The Committee was still concerned that the risks were not relayed to Complainant at this time.

The medical treatment provided by Respondent was appropriate and birds can get easily stressed with minimally restraint. Some Committee members felt that Respondent touched upon anesthesia and Complainant did not having any questions about potential complications with anesthesia. However, Respondent admitted to not going over the anesthetic risks in detail because she felt Complainant must have known about that from previous anesthetic procedures. Although it is not known how the bird was anesthetized at a previous premise or if the risks were explained to Complainant previously.

The outcome would not have changed unless the risks were explained and Complainant elected to not proceed with the procedure based on the information provided to her.

The Committee would have been more comfortable if Respondent documented in the medical record that she went over the risks. It also appeared that the technical staff was there to go over the costs not necessarily to witness authorization of anesthesia – it would have been clearer if this information was detailed in the medical record.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the *Veterinary Practice Act* occurred.

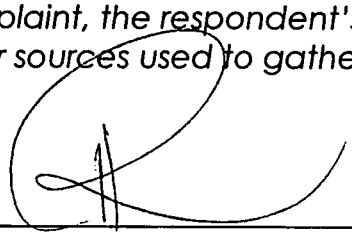
COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board find:

ARS § 32-2232 (12) as it relates to AAC R3-11-501 (1) failure to provide professionally acceptable procedures for not documenting that the risks of anesthesia were communicated to the pet owner.

Vote: The motion was approved with a vote of 3 to 2 (Dr. Rai and Mr. Almaraz opposed).

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.



Tracy A. Riendeau, CVT
Investigative Division